Advising the Congress on Medicare issues

Accountable care organizations

David Glass, Jeff Stensland

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Why Medicare may want ACOs

- Medicare needs mechanisms for controlling cost growth and improving quality
  - Constraining FFS rates, readmissions, other policies
  - ACOs could help control volume growth by tying bonuses and penalties to overall Medicare spending
- Objectives
  - Delivery system reform; improve care coordination and collaboration
  - Tie payments to quality and resource use
  - Achieve a sustainable Medicare spending growth rate
  - Allow physicians and hospitals to share in efficiency gains

Our ACO concept

- Physicians and a hospital have joint responsibility for the quality and cost of care delivered to a population of patients
- Bonuses for high quality and low cost growth
- Penalties for low quality and high cost growth

Note: Cost growth is the rate of increase in overall Medicare spending per beneficiary assigned to ACO

ACO size and incentives

- ACOs need to be large enough so that changes in quality and resource use could be measured with some confidence (at least 5,000 patients)
- Problem: ACO incentives for individuals to restrain volume may be too small to overcome FFS incentives
- Opportunity: Incentives for joint actions could be large enough to overcome FFS incentives and constrain capacity growth
  - Change patterns of care
  - Savings from constraining capacity will take time
- Capability for ACO to make joint decisions

FFS incentive overpowers ACO incentive for an individual's decision

	Effect of an ACO on a decision to: Order an MRI image
MRI revenues	$500
Costs (marginal)	100
Profit (marginal)	400
Medicare spending	500
Effect on ACO bonus	-$500 x .5 x .8 = -$200
Net incentive	**+ 200**

Note: assumes probability of earning a bonus is .5, share in savings is .8

Joint decisions could limit capacity

	Effect of an ACO on a decision to:	
	Order an MRI image	Sign annual lease for MRI machine
MRI revenues	$500	$500,000
Costs (marginal/annual)	100	450,000
Profit (marginal/annual)	400	50,000
Medicare spending	500	250,000
Effect on ACO bonus	$500 x .5 x .8 = $200	-$250,000 x.5 x.8 = -$100,000
Net incentive	**+ 200**	- 50,000

Note: assumes probability of earning a bonus is .5, share in savings is .8

Illustrative bonuses and penalties based on performance over three years

Cost over 3 years	Quality over 3 years: Meets target all 3 years	Mixed	Fails target all 3 years
Meets target all 3 years	Return withhold + share of savings (i.e. bonus)	Return withhold	Withhold not returned (i.e. penalty)
Mixed	Return withhold	Return withhold	Withhold not returned (i.e. penalty)
Fails target all 3 years	Return withhold	Return ½ withhold	Withhold not returned (i.e. penalty)

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Potential method of setting ACO-specific Medicare spending targets

		ACO spending		
	National average	Low	Average	High
Base spending	$10,000	$7,000	$10,000	$12,000
$ target growth	500	500	500	500
Target spending	$10,500	$7,500	$10,500	$12,500
% target growth	5.0%	6.3%	5.0%	4.2%

Assumption: Wage index = 1, risk score = 1

Example of a bonus/penalty calculation

ACO Quality	ACO base spending per capita	Target spending Year X	Actual FFS billing Year X	Withhold (10% of FFS)	Bonus (80% of savings)	Net Medicare payment
High	$7,000	$7,500	$7,000	$700 (returned)	$400	$7,400
Low	7,000	7,500	8,000	800 (not returned)	0	7,200

- High quality ACO can slow FFS billing growth (volume) and increase net income
- Medicare reduces payments for poor quality care

Two possible ACO paths

1. Voluntary ACO
   - Need to be attractive to providers
   - Most designs are bonus only (e.g. Fisher, CBO)
   - Providers have to be organized to participate
2. Mandatory ACO
   - Poor quality and rapid spending growth can be penalized
   - Incentive to organize

- Spending = FFS rates x volume
  - ACO still paid national FFS rates
  - Voluntary: weaker volume incentive → Lower FFS rate
  - Mandatory: stronger volume incentive → Higher FFS rate

PGP demonstration

- Voluntary, big practices (avg. 20,000 patients)
- Improved quality
- No Medicare savings to date
- Changes in design could improve prospects for savings

Strengthening ACO design

- Target known in advance
- Information flow to providers
- Permanence of incentives
- Involvement of other payers
- Withholds in addition to bonuses
- Measuring performance over three years

ACO issues for discussion

- Should ACOs be used to constrain volume growth?
  - Penalties for no reduction in volume growth?
  - How should bonuses and penalties be structured?
- Which path: voluntary or mandatory?